CREW SPEECH & LANGUAGE GROUP
2015 OSBORNE RD UNIT A
ST MARYS GA 31558
PHONE: 912-576-9603 FAX: 912-576-9865

HIPAA – Patient Acknowledgment Form

Patient's Name: _____ DOB: _____

Our Notice of Privacy Practices (NPP) provides information about how Crew Speech & Language Group may use and disclose protected health information (PHI) about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NPP contains a Patients Rights section describing your rights under the law. Please review the NPP pamphlet thoroughly before signing this acknowledgement form. In the event that terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment, and healthcare operations. You have the right to restrict how PHI is used or disclosed for treatment, payment or healthcare operations.

I give permission for Crew Speech & Language Group to:

Leave a message via phone, email or text message regarding an appointment at: _____ (phone)

Share medical information with (You may choose as many as two persons):

(1) Name _____ Relationship _____

Phone: _____

(2) Name _____ Relationship _____

Phone: _____

Please check off the boxes below:

☐ I assume responsibility to inform the practice of any changes in the above information

☐ I have received the most recent Notice of Privacy Practices (NPP) pamphlet.

Patient's Signature: _____Date: _____

Relationship to patient (if other than self):_____

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )		ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1				A				NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd.for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.		

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

CREW SPEECH & LANGUAGE GROUP
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Billing/Payment Policy

CREW SPEECH & LANGUAGE GROUP is dedicated to providing you with high quality Speech/Language Evaluations and Therapy. We are in-network providers with most insurance companies and will submit invoices to them for payment on your behalf.

1. Clients wishing to use insurance benefits need to provide **CREW SPEECH & LANGUAGE GROUP** with their current insurance information when scheduling the first appointment. We will verify benefits and obtain necessary authorizations.
2. Verification of benefits is not a guarantee of payment and it is the clients' responsibility to call the customer service number on the back of their insurance card to have a full understanding of what services are covered. It is also the clients' responsibility to notify **CREW SPEECH & LANGUAGE GROUP** of any insurance changes. Failure to do so, which could result in a claim denial will then be the responsibility of the client to pay.
3. It is your responsibility to know your co-pay, deductible, and co-insurance prior to your initial appointment. Clients are required to pay for all sessions at the time of service, unless coverage through an insurance plan for which we are providers has been verified. Speech/Language fees are $200.00 for an initial assessment and $90.00 for Speech/Language Therapy sessions. Payments are accepted by means of check, cash, or credit card.
4. CO-PAYMENTS, in the form of check, cash, or credit card must be made at the time of service. **We cannot waive co-pays, co-insurance or deductibles due to requirements by the insurance companies.**
5. Statements will be provided to clients the first week of the month and for clients with balances due, payment is required upon receipt. A 10% surcharge is added to accounts overdue 30 days and an additional 1.5% per month is added thereafter. Service(s) may be temporarily interrupted for past due balances until arrangements for payment is made.
6. If financial difficulties or hardship arise, the client must call **CREW SPEECH & LANGUAGE GROUP** to make acceptable payment arrangements. These arrangements will be determined on a case-by-case basis.
7. A client may leave therapy at any time, and by signing this document client agrees to pay all outstanding fees associated with their account immediately. Failure to do so will result in additional fees being assessed, Cancellation/No Show Policies

CANCELATION POLICY

• CANCELLATION OF SCHEDULED APPOINTMENTS must be done with a 12-hour notice (you can leave a voicemail on our office phone which time stamps the message 912-576-9603 or on the cell phone number of 912-674-3932 via text or call). We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at is most efficient level. Due to our one-on-one 30-minute treatments, missed appointments are a significant inconvenience to your speech/language therapy, the clinic and other patients.

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With regard to commercial insurance and self-pay therapy clients, **if this 12-hour requirement is not met, a $30 late-cancel/no-show fee will be assessed. If a client is able to reschedule the missed appointment within the same week, fees will not be assessed.** Insurance companies do not pay for missed appointments. Other instances of this fee being waived will only be considered on a case by case basis due to client extenuating circumstances and administrative approval. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

• If three therapy appointments are missed within a two-month time period, either by "late cancellation" or "no-show," you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance. Termination of services may also be considered by **CREW SPEECH & LANGUAGE GROUP**.

• Insurance companies expect regular attendance to speech/language therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your authorization for therapy.

Written Acknowledgement of Billing & Cancellation Policies

I have read this document and it has been fully explained to me. I understand fully and agree to the terms laid out in this document.

Please Initial for Payment for Services

_____ • I hereby authorize **CREW SPEECH & LANGUAGE GROUP** to release all billing and medical information regarding my diagnosis and therapy treatment applicable to any third party payer, when such information is requested for payment utilization review or coverage determination purposes.

_____ • I am making payment for services directly through self-pay; therefore, I am not authorizing a release of information for billing purposes. Reminder Notifications for Services & Cancellation Policy

• I understand that reminder notifications for ongoing sessions are a courtesy of **CREW SPEECH & LANGUAGE GROUP** and will be made via text messaging and phone calls. I understand that I am fully responsible to remember and attend my scheduled appointments even if this service fails.

• I understand **CREW SPEECH & LANGUAGE GROUP** cancellation policies and agree to provide the required notification if I must cancel my appointment.

My signature below means that I understand and agree with all of the points above.

Patient/Client Signature_____ Date _____

Print Name_____

Parent/Guardian Signature if client is a minor_____
Date_____

Print Name_____

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AUTHORIZATION FOR BILLING AND INSURANCE
CONSENT TO RELEASE PRIVATE DATA

Crew Speech & Language Group 2015 Osborne Rd Unit A St Marys, Ga 31558
• 912-576-9603 • fax 912-576-9865 • www.crewspeech.com

Name of Patient: _____ DOB: _____
I hereby authorize **Crew Speech & Language Group** to use or disclose health information about myself or child (if under 18). The use or disclosure shall be limited to the information, persons, purposes, and time frame described below.

Information to be used or disclosed I authorize the use or disclosure of the following protected health information created from _____ (date) to _____ (date).

Speech-Language Records - I hereby authorize **Crew Speech & Language Group** to release information to and obtain information from:

CHECK BELOW WHERE TO FAX REPORT/INFORMATION TO:

☐ _____ _____ _____
School **Phone** **Fax**
_____
School Address

☐ _____ _____ _____
Other **Phone** **Fax**
_____
Address

☐ _____ _____ _____
Physician **Phone** **Fax**
_____
Physician Address

I understand that I may change this authorization at any time.

_____
Patient/Parent /Guardian Signature Date

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Today's Date_____

I. Identifying Information
Child's Name_____ Age_____ Birthdate_____
Sex of Child_____

Child's Home
Address_____

Names of Parents/Guardian_____
Mother _____Occupation_____
Address_____
Phone: Home ( )_____Work ( )_____
Father_____ Occupation_____
Address_____
_____
Phone: Home ( )_____ Work ( )_____

Are languages other than English (including sign language) used at home?
_____yes _____no
If so, what language?_____

II. Child Referred By:
Name_____
Relationship to Child_____
Address_____
City_____ State_____ Zip_____
Telephone ( )_____
Reason for referral:_____
_____
_____

Insurance Name: _____
Insurance Policy Number: _____

Person completing
questionnaire:_____

III. Statement of Concern
Describe your concerns about your child's speech/language and hearing:_____
_____
_____

1. When was this concern first noticed? _____

2. What do you expect from this evaluation? _____
_____

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4. Hearing
Date of most recent hearing evaluation_____Results_____
Where was testing performed?_____
By Whom?_____
Yes No
___ ___ Do you feel that the child hears well?
___ ___ Has the child ever been exposed to a loud noise or explosion?
___ ___ Has the child ever had an ear infection? If so, which ear_____
Last occurrence _____First occurrence _____Frequency _____
___ ___ Does the child presently have or in the past had draining ears (pus, blood, etc.)?
___ ___ Does the child ever complain of ear noises (tinnitus) such as ringing, buzzing, pulsing, etc.?
___ ___ Is the child able to locate the direction from which sound is coming?
___ ___ Does your child hear the same from day to day?
___ ___ Does your child favor one ear? If so, which ear_____
___ ___ Does your child respond to vibration caused by loud sounds (door slam, truck driving by, airplane, radio in car, boom box vibration, etc.)?
___ ___ Does the child watch the speaker's face when listening?
___ ___ Does your child wear hearing aids?
Right ear_____ Left ear_____ Both ears_____
Make and Model_____
How long has he/she worn hearing aids?_____
How many hours a day does your child wear the hearing aids?_____

Speech/Language
1. Did the child begin to babble or talk and then stop? ___yes ___no
If yes, please explain_____
_____

2. Please indicate all means of communication currently used:
___Speech ___Vocalizations ___Bodily Gestures
___Facial Gestures ___Gestural (yes/no) ___Takes to item physically
___Spoken (yes/no) ___Manual Signs ___Pointing
___Augmentative Communication Device
List any adaptive equipment currently used:
_____

3. At what age did your child say his/her first word? _____
What were the child's first few words?_____

4. Approximately how many words did the child have at
18 months?_____ 24 months?_____

5. At what age did the child say his/her first sentence?_____
Please give some examples of first sentences:_____
_____
_____
Please give an example of typical sentences the child currently uses:_____
_____
_____

6. How often does your child use speech? ___Frequently ___Sometimes ___Rarely

7. How does your child make his/her needs known?_____

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8. Does the child use gestures often? ___yes ___no if so, give an example_____
_____

9. What does the child use the most?
___Gestures ___Sounds ___One or two words ___Phrases ___Complete sentences

10. Estimate the percentage of time that the child is understood by:
___Unfamiliar listeners ___Parents ___Other adults ___Brothers and Sisters ___Friends

11. How well does the child understand what is said to him/her?_____

12. Please indicate the child's current level of understanding by checking those that apply:
___Understands gestures
___Does not understand spoken words
___Understands single words
___Understands simple sentences
___Understands 2 and 3 part commands
___Understands conversation

13. Do you think the child is aware of his/her communication difference? ___yes ___no
If yes, please describe how the child shows awareness._____
_____
_____
_____

14. Provide any other information about your child's communication that is of concern to you.
_____
_____
_____

15. What have immediate family and/or relatives done to help the child overcome his/her communication difficulty?
_____
_____
Has this helped?_____

16. What do you think caused this communication difference?_____
_____
_____
_____

17. Please provide any additional information you feel will help us in understanding the child and his/her present communication ability._____
_____
_____

IV. Prenatal (pregnancy), Birth, and Development

1. **Prenatal**

Mother's age when child was born_____ Father's age when child was born_____
Length of pregnancy in weeks_____

Yes	No	
___	___	Did the mother experience bleeding during pregnancy?
___	___	Did the mother have measles during pregnancy?

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___ ___ Did the mother have high blood pressure during pregnancy?
___ ___ Did the mother experience leakage of membranes during pregnancy?
___ ___ Were there complications during this pregnancy? (anemia, dehydration, diabetes, kidney infection, sever nausea, toxemia, accidents, other)
If so, please describe condition and medical attention received_____
_____
___ ___ Were prescription/non-prescription drugs (including alcohol) taken during pregnancy? If so, please list_____

2. **Birth**
Yes No
___ ___ Did the mother have a normal delivery with this child?
___ ___ Breech delivery?
___ ___ Caesarean Section delivery?
___ ___ Were there birth injuries? Please describe_____
___ ___ Breathing difficulties (e.g., blue baby, required oxygen, stopped breathing, apnea, other_____)
___ ___ Special instruments used during delivery?
___ ___ Please describe_____
___ ___ Was the baby jaundiced at birth?
___ ___ Rh incompatible?
Birth weight_____ One minute Apgar_____ Five minute Apgar_____
Were there any problems or complication immediately following birth or during the first two weeks of your infant's life (feeding, seizures, sleeping, swallowing, hospitalizations, etc.)?_____
_____
_____
How long was the infant's stay in the hospital following birth?_____

3. **Development** (give age when first occurred)
_____Held head up _____Reached for object
_____Sat up unsupported _____Crawled
_____Stood alone _____Walked alone
_____Fed self with spoon _____Bladder Trained
_____Bowel trained _____Dressed Self
_____Undressed Self

What motor &/or self-help development concerns do you have for this child?_____
_____
_____
Would you describe your child's coordination as: _____good _____fair _____poor
Explain_____
_____

V. Child's Medical History
Name of child's Pediatrician/Doctor_____
Address_____Telephone_____
City_____State_____Zip_____

Please check all conditions that your child has had or presently has:
General
___allergies ___asthma ___blood disease
___chicken pox ___convulsions ___crossed eyes
___croup ___dental problems ___diphtheria
___encephalitis ___epilepsy/seizures ___apraxia

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___headaches ___head injury ___dysarthria
___heart problems ___high fevers ___influenza
___measles ___meningitis ___mumps
___muscle disorder ___nerve disorder ___traumatic brain injury
___pneumonia ___polio ___bronchopulmonary dysplasia
___rheumatic fever ___cerebral palsy ___tracheostomy
___whooping cough ___stroke ___RSV
___CHARGE association ___Failure to Thrive ___CMV (Cytomegalovirus)
___Feeding or swallowing ___HIV ___Gastroesophageal reflux
problems ___Fetal Alcohol Syndrome ___Neonatal Drug Dependence

Visual

1. Does your child wear glasses? ___yes ___no
2. Does your child have any visual problems? ___yes ___no If so, describe:_____
_____
_____
3. Date of most recent vision testing_____
4. Where was the testing done?_____
5. By whom was the testing performed?_____

Ear, Nose, and Throat

Please check all conditions that your child has had or presently has:
___chronic cough/colds ___hoarse voice ___difficulty swallowing
___tonsillitis ___tonsillectomy ___adenoidectomy
___tongue deformity ___jaw deformity ___cleft palate/lip
___speech problem ___ear deformity ___dizziness
___too much wax in ears ___pressure equalization tubes
Please list any medications the child is taking presently:_____
_____

If your child has been seen by a medical specialist, hospital, clinic, agency, etc., please list below:
Agency/Specialist_____ Date_____
What was done _____
Results/Recommendation_____
Name_____
Address_____
Phone_____
Name_____
Address_____
Phone_____
Name_____
Address_____
Phone_____
Name_____
Address_____
Phone_____

VI. Educational History

Does your child attend ___day care ___kindergarten ___school ____other
Name of School: _____Current Grade: _____ Type of Class_____
Address_____Phone_____
City_____County_____State_____Zip_____
Teacher's Name_____
Name of Speech Language Pathologist_____
Name of Principal_____

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Previous Schools Attended:
Name of School Address Dates Attended
1._____ _____ _____
_____ _____
2._____ _____ _____
_____ _____
3._____ _____ _____
_____ _____
Current grades for: Reading_____ Language_____ Spelling_____ Math_____
Does your child have a current IEP? ___Yes ___No
If yes, please have the school send a copy to this center.

VII. Cognitive History
Psychological Evaluation Completed:_____
Date of most recent test: _____
Where tested: _____
By Whom? _____
Test Results: _____
_____
*Please provide the center with a copy of the Evaluation Report.

VIII. Home and Family
Please list other family member(s) who have a hearing loss (before age 50) or speech/language or
learning difficulties (brothers, sisters, mother, father, and extended family such as grandparents, cousins, etc.):
Communication/ Relation to
Name Date of Birth Age Sex Learning Concern This Child
_____ _____ ___ ___ _____ _____
_____ _____ ___ ___ _____ _____
Please list everyone who lives with this child (i.e., brothers, sister, grandparents):
Name Age Sex Relationship to this child
_____ ___ ___ _____
_____ ___ ___ _____
_____ ___ ___ _____

IX. List significant activities, interests, events, hobbies, favorite toys, etc. for this child.
_____
_____
_____
_____
_____
The assessment cannot proceed without the signature of the legal guardian.

Signature of Parent/Guardian_____ Date_____